**Health Equity**

**Framework**

1. What is equity?
2. What is equity in health and health care?
3. Why focus on equity in health and health care
4. Health inequity in India
5. Causes of health inequity
6. How to measure Health equity
   1. Concentric curves
7. Principles for action for equity in health
8. How equity is/can be ensured
   1. through intersectoral coordination

**What is equity?**

**Equity** is the absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically, or geographically.

In other words people’s needs rather than social privileges should guide the distribution of opportunities for well being.

Equity in development means a fair sharing of progress, not an equitable distribution of avoidable misery and deprivation.

***The term inequity has a moral and ethical dimension. It refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust. So, in order to describe a certain situation as inequitable, the cause has to be examined and judged to be unfair in the context of what is going on in the rest of society.***

**What is equity in health and health care?**

1. **Equity in health**

***Inequity in health refers to differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust.***

Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided .

Equity is therefore concerned with creating equal opportunities for health and with bringing health differentials down to the lowest level possible.

***Judgements on which situations are unfair will vary from place to place and from time to time, but one widely used criterion is the degree of choice involved***. Where people have little orno choice in living and working conditions, the resulting health differences are more likely to beconsidered unjust than those resulting from health risks which were chosen voluntarily. Thesense of injustice increases for groups where disadvantages cluster together and reinforce eachother, making them very vulnerable to ill health.

**Health inequities,** therefore, involve more than inequality (sameness)—whether in health determinants or outcomes, or in access to the resources needed to improve and maintain health. Health inequities also emphasize a failure to avoid or overcome such inequality that infringes human rights norms or is otherwise unfair.

**Inequality in health** is a term commonly used in some countries to indicate systematic, avoidable and important differences. However, there is some ambiguity about the term, as some use it to convey a sense of unfairness while others use it to mean unequal in a purely mathematical sense.

**Unavoidable *determinants of health differentials*** :

1. Natural, biological variation.

2. Health-damaging behaviour if freely chosen, such as participation in certain sports and pastimes.

3. The transient health advantage of one group over another when that group is first to adopt a health-promoting behaviour (as long as other groups have the means to catch up fairly soon).

Some situations are the result of a much greater degree of choice. For example, skiing injuries suffered more frequently by certain groups would not arouse the same sense of injustice, since the cause – skiing – is widely viewed as a voluntary activity chosen by those who accept and insure against the risks involved. Similarly, a section of the population may freely choose not to use a particular health service because of religious beliefs, for example, and any resultant excess in sickness in that group would not normally be classed as unfair. These would not normally be classified as inequities in health.

**Avoidable *determinants of health differentials*** :

1. Health-damaging behaviour where the degree of choice of lifestyles is severely restricted.
2. Exposure to unhealthy, stressful living and working conditions.
3. Inadequate access to essential health and other public services.

For example, through lack ofresources, poorer social groups may have little choice but to live in unsafe and overcrowdedhousing, to take dangerous and dirty work, or to experience frequent bouts of unemployment.The higher rates of ill health resulting from such environmental factors are clearly inequitable.The sense of injustice is heightened in such cases as *problems tend to cluster together and reinforce each other, making some groups very vulnerable to ill health*. Many disabled people appear to suffer a cycle of injustice in this respect. Through circumstance largely outside their control they shoulder a heavy burden of ill health and in addition, their impairment can reduce their employment and earning opportunities. This in turn means that theymay have to live in disadvantaged conditions which may endanger their health still further.

Likewise, ***personal health behaviour options may be severely restricted by social and economic***

***considerations***. For example, a less nutritious diet may be chosen because of restrictions on

income or inadequate food distribution networks leading to lack of fresh supplies in the shops.

Less physical activity may be undertaken because of lack of leisure facilities or of income or time to make use of them. Promotion of health-damaging products may be targeted at certain groups in society, such as young working-class men and alcohol advertising or young women and tobacco promotion. This puts them under greater pressure than others to consume these products. These are avoidable and the resultant health differences to be unjust.

Another determinant i.e involving the tendency for sick people to become poor, the original ill health in question may have been unavoidable but the low income of sick people seems both preventable and unjust.

1. **Equity in health care is defined as:**

— equal access to available care for equal need

— equal utilization for equal need

— equal quality of care for all .

It focus on accessibility, quality and acceptability of the care offered to all sections of the population.

Health services based on equal expenditure per capita doesn’t to satisfy a common sense of fairness. By this definition an equitable allocation would be achieved if the available health service budget were divided equally amongst geographical areas based on the size of population in each area. But even if this were attained, it would make no allowance for the differential needs for care in different age and social groups in each region and so would not be considered equitable by many.

At the other extreme, the most ambitious definition maintains that equity in health care is

achieved when equal health status has been attained. In other words, the goal of an equitable

health service would be to make the level of health the same in all regions and/or social groups,

or at least to narrow the health gap significantly. In practice, this is an unrealistic goal for most

services, because health care is only one of many factors which contribute to health differences in a country and acting in isolation would not be able to bring about the required improvement in

community health status.

**Accessibility to health services:** Equal access to available care for equal need implies equal entitlement to the available services for everyone, a fair distribution throughout the country based on health care needs and ease of access in each geographical area, and the removal of other barriers to access.

Barriers to accessing health services can be:

* Health facility far away or inconvenient opening hours for clinics
* Not able to pay for service pay including transport costs fall most heavily on low-income groups
* Ethnic minorities may find the language and cultural barriers to access .
* Resources and facilities are scarce in deprived and rural neighborhoods.
* Little resource are allocation to the primary health care services of benefit to the majority.

**Utilization of services**: when use of services is restricted by social or economic disadvantage, there is a case for aiming for equal utilization rates for equal need. For instance, in relation to immunization and other preventive services, positive discrimination may be justified in providing outreach and other imaginative schemes to make it easier for people to use services in low take-up areas.

**Quality of care:**With regard to the concept of equal quality of care, it is very important in many societies that every person has an equal opportunity of being selected for attention through a fair procedure based on need rather than social influence. This issue arises most critically when resources are scarce or are being cut back. In such a climate it would seem unfair to many if one social group consistently obtained preferential service over less favoured groups, or conversely, if other groups, because of race or ethnic origin for example, were consistently pushed to the back of the queue for treatment. Rehabilitation services are also scarce in many countries; they often concentrate on getting people back to work and so are biased in favor of people with jobs and against the selection of the unemployed, retired people and housewives. Yet rehabilitation in the widest sense of the word can have an immense impact on a person’s quality of life. Equal quality of care for everyone, also implies that providers will strive to put the same commitment into the services they deliver for all sections of the community, so that everyone can expect the same high standard of professional care. Inequities arise in this case when professionals do not put the same effort into their work with some social groups as with others, offering them less of their time or professional expertise. For example, there is evidence from the India of doctors giving shorter consultations to lower-class patients and referring them less frequently to specialist services. There is also evidence of quality of care being compromised by poor quality of premises in disadvantaged areas and reluctance of more experienced staff to work in such conditions. Acceptability is another important component of the quality of care. It may be that some services are inequitable in the way they are organized, making them unacceptable to some

sections of the community that they are intended to serve. Only by monitoring acceptability with the users of services will defects of this nature be revealed. Steps can then be taken to make

such services more user-friendly.

**Why focus on equity in health and health care**

1. **Social gaps in health and in health care** are unacceptably wide and widening both in developing and industrialized countries. T*here is consistent evidence that disadvantaged groups have poorer survival chances*. *Disadvantaged groups not only suffer a heavier burden of illness than others but also experience the onset of chronic illness and disability at younger ages*. *Other dimensions of health and wellbeing show a similar pattern of blighted quality of life*. In general that those most in need of medical care, including preventive care, are least likely to receive a high standard of service (inverse care law).
   1. Gaps between socioeconomic groups: rich-poor; nonprofessional and professional
   2. Gaps between geographical groups: interstate, rural- urban
   3. Gender gap in health: neglect and discrimination of females
   4. Gaps between racial/ethnic groups: indigenous/ noningenous ; white/ non white
   5. Gaps between age groups
2. Countries are finding it difficult to implement and sustain equitable policies
   1. Worsening overall health statistics in some countries
   2. Alarming trend s in some countries that have historically put high priority on equity
   3. Structural adjustment has been widely associated with deterioration in conditions for vulnerable groups
   4. Cost recovery in the health sector may be inherently inequitable and in efficient
   5. Economic recession and weak economic performance also threatens equity
3. Routine information often hides the gaps or fail to result in effective action
4. Social spending is being constrained by many powerful pressures, both economic and political
5. Equity in health and health care must be placed higher on public policy agenda
   1. Short-term and unsustainable efficiency gains are often used to justify inequitable decisions.
   2. Short-term gains are more easily measurable than long-term progress.

So from the **practical point of view** of designing effective and efficient health policies, differences on such a large and persistent scale have to be taken seriously and provision made for reducing them.

From an **economic standpoint** can any country afford to have the talent and performance of sizeable sections of the population stunted to such an extent?

Above all, on **humanitarian grounds** national health policies designed for an entire population cannot claim to be concerned about the health of all the people if the heavier burden of ill health carried by the most vulnerable sections of society is not addressed. Both health and health care are human rights. The bias against these social groups in the provision of health care also offends many people’s sense of fairness and justice once they learn of its existence. Disregard for equity is socially destabilizing and can jeopardizes the health for anyone because of spillover effects (crime, infectious disease, greater costs for treatment than for prevention).

**Health inequity in India**

To appreciate the importance of striving for equity in relation to health, it is necessary to be aware of just how extensive are the differentials in health found in India today. *In every part of*

*the Region, and in every type of political and social system, differences in health have been*

*noted between different social groups in the population and between different geographical*

*areas in the same country*.





**Cause of Health Inequity**

**Conceptual framework**

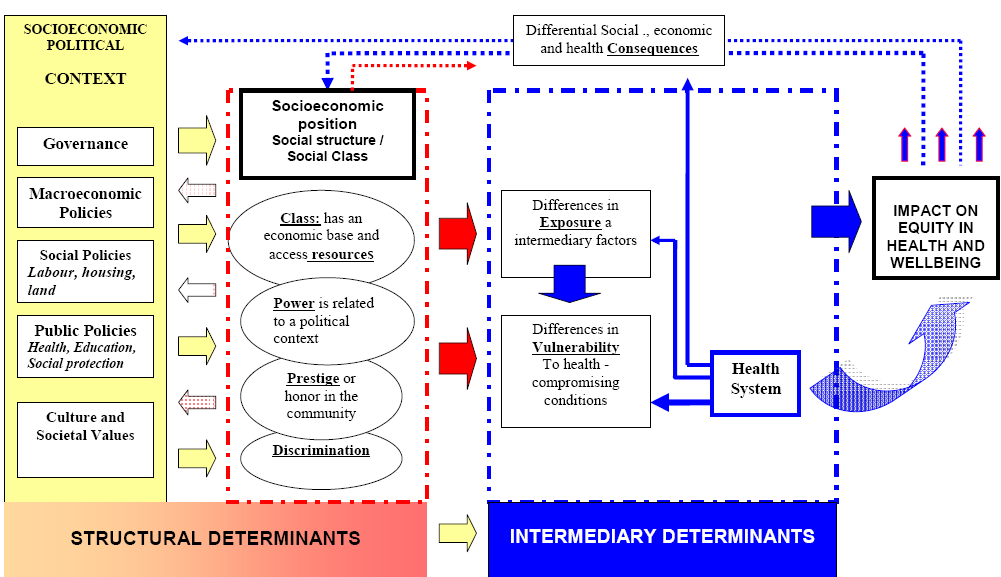
The conceptual framework used largely synthesizes models proposed by Dahlegren, Whitehead, Diederichsen, Hallqvist, etc., and were proposed for use by the Commission on Social Determinants of Health. This conceptual model illustrates the pathways by which social determinants of health affect health outcomes, makes explicit the linkages among different types of health determinants, and makes visible the ways social determinants contribute to health inequities among groups in society, given the increasing evidence of significant social stratification in health status. This conceptual framework served as the departure point on how to "operationalize" or make concrete monitoring and assessment, with the initial purpose of describing levels and potentially linkages across components within national settings. The key

components of the model are summarized here:

**1. Socioeconomic-political context:** this encompasses a broad set of structural, cultural and functional aspects of a social system whose impact on individuals tends to elude quantification but which exert a powerful formative influence on patterns of social stratification and thus on people's health opportunities

**2. Socioeconomic position:** within each society, material and other resources are unequally distributed. This inequity can be portrayed as a system of social stratification or social hierarchy. People attain different positions in the social hierarchy according, mainly, to their social class, occupational status, educational achievement and income level. Their position in the social stratification system can be summarized as their socioeconomic position.

**3. Intermediary determinants:** intermediary factors flow from the configuration of underlying social stratification and, in turn, determine differences in exposure and vulnerability to health-compromising conditions. The main categories of intermediary determinants of health are: material circumstances; psychosocial circumstances; behavioral and/or biological factors; and the health system itself as a social determinant.



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**Measuring Health Equity**

1. **The range**
2. **Index of dissimilarity**
3. **Population attributable risk**
4. **Slope and relative index of inequality**
5. **Gini coefficient (and associated Lorenz curve)**
6. **Concentration index and the concentration curve**

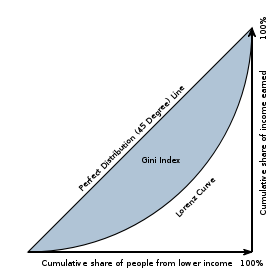
**Gini coefficient (and associated Lorenz curve)**

The Lorenz curve plots the cumulative percentage of a health variable against

the cumulative percentage of the sample, ranked by their health, starting with

the sickest person and ending with the healthiest.

The Gini coefficient, denoted by G, is defined as twice the area between the Lorenz curve and the diagonal. It ranges from 0 (when there is no inequality) to 1 (when all the population’s health is concentrated in the hands of one person).

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**Concentration index and the concentration curve**

**The concentration curve** plots the cumulative percentage of the health variable against the cumulative percentage of the sample, ranked by their socioeconomic status, beginning with the most disadvantaged, and ending with the least disadvantaged.

The concentration index is defined with reference to the concentration curve. The health concentration index, denoted by C, is defined as twice the area between the concentration curve and the line of equality. So, in the case where there is no socioeconomic inequality, the concentration index is zero. The value of the concentration index can vary between –1 and +1. Its negative values imply that a variable is concentrated among disadvantaged people while the opposite is true for its positive values. When there is no equality, the concentration index will be zero. If the health variable is "bad", such as infant death, a negative value of the concentration index means it is higher among the most disadvantaged. If the health variable is equally distributed among socioeconomic status, the concentration curve will be a 45° line. This is known as the line of equality. If, by contrast, the health variable takes higher (lower) values among people with lower socioeconomic status, the concentration curve will lie above (below) the line of equality. The further the curve lies from the line of equality, the greater the degree of inequality in health.



**Principles for action for equity in health**

1. Equity policies should be concerned with **improving living and working conditions.**
2. Equity policies should be directed towards **enabling people to adopt healthier lifestyles.**
3. Equity policies require a **genuine commitment to decentralizing power and decision making.**
4. Equity policies should **encourage people to participate** in every stage of the policy-making process.
5. Equity policies should be implemented **through inter-sectoral action.**
6. Equity policies should be **based on appropriate research, monitoring and evaluation.**
7. **Equity policies should be concerned with improving living and working conditions.**

Because most of the present inequities in health are determined by living and working conditions, attempts to reduce them need to focus on these root causes, with the aim of preventing problems developing. This is potentially a more efficient approach than relying solely on the health care sector to patch up the ill health and disability such inequities create.

Several public policies, although designed to benefit the population as a whole, can have the most dramatic impact on people living in the worst conditions, by helping to raise the standards of their physical and social environment to a level closer to that of a more fortunate group. In doing so, such policies encourage equity in health.

**Examples** include those policies designed to provide adequate and safe housing; to ensure the provision and accessibility of high quality food together with nutritional information; to raise the standard of occupational health and safety practice; to control pollution, and to ensure clean water supplies. More specific preventive policies related to equity would include such measures as the maintenance of full employment and the raising of income of poorer socioeconomic groups, reducing the gap between rich and poor.

1. **Equity policies should be directed towards enabling people to adopt healthier lifestyles.**

The principle of enabling people to adopt healthier lifestyles acknowledges that some groups in society face greater restrictions than others in their choice of lifestyle due, for example, to inadequate income, which limits where and how people live. Local and national agencies therefore need to make healthier lifestyles as easy to adopt as possible. This means, for instance, looking at:

• whether leisure and exercise facilities in the community are accessible and reasonably priced;

• whether food distribution networks are adequate to ensure supplies of cheap and nutritious food in local shops;

• whether advertising and promotion of health-damaging products is controlled and restricted;

• whether products are clearly labelled so that people have adequate information on which to base their choice, and so on.

The process of enabling people to adopt healthier lifestyles also involves the recognition that some social groups may come under greater pressure to adopt health-damaging behaviour, and sensitive policy-making is needed to deal with this issue. In particular, health education and disease prevention policies need reorientation, bearing in mind the fact that traditional health education programmes have generally been less successful at reaching the vulnerable groups in greatest need. They may even have been counter-productive if they stimulated defensive reactions in certain social groups by blaming them for their own ill health. “Blaming the victim” can cause people to reject the advice offered and to refuse to take part in any improvement programmes. New educational programmes are needed based on giving support to and encouragement for lifestyle changes and helping to develop the skills required to maintain those changes against negative social pressures.

1. **Equity policies require a genuine commitment to decentralizing power and decision making**

This is too often interpreted in a very restricted sense by professional planners, who acknowledge little more than that they need the public to cooperate willingly in order for official plans to work. The principle, however, goes beyond this to the acceptance that plans and actions should be based on what people feel are their own needs, not on solutions imposed from the outside. The point is that projects and plans to reduce inequities are things done not to people but with them. Plans should be as much those of the public as of the planners.

This means that administrators and professionals need to make a determined effort to provide

administrative systems and information to make it easier for lay people to participate. They need to find ways in which people can express their needs, particularly vulnerable groups who may not have the skill or confidence to use existing arrangements without positive encouragement. An awareness of equity issues at every level is essential for these policies to work, and this in turn requires an educational input for professionals and non-professionals at each level.

1. **Equity policies should encourage people to participate in every stage of the policy-making process.**

Disadvantaged and vulnerable groups who tend to have the least say and the lowest participation rates in key decisions affecting their health and wellbeing. The more articulate members of the population and those with the most powerful representation tend to have more influence than others in a weaker position. This situation can also arise with residents of outlying regions of a country, distant from the centre of decision-making, who may feel that their views and needs have been ignored.

1. **Equity policies should be implemented through inter-sectoral action.**

The vision of the Commission on Social Determinants of Health launched by the World Health Organization (2005-2008), is “a world in which all people have the freedom to lead lives they have reason to value”. The complexities of the social, political, economic and environmental factors that influence health and inequalities in health, and the fact that most of these determinants lie outside of the exclusive jurisdiction of the health sector, requires the health sector to act in collaboration with other sectors of government and society in order to more effectively address those factors that influence health and well-being. Recognition of the intersectoral dimensions of the determinants of health has stimulated international efforts on systematic learning about how the action of different sectors can positively influence health and health equity.

Having accepted that the determinants of inequities lie in many different sectors, there is obviously a need to look at policies in all sectors, assessing their likely impact on health, and especially on the health of the most vulnerable groups in society, and to coordinate policies accordingly. Collaboration and coordination on such a scale does not happen of its own accord. Competition and rivalry for resources between ministries inhibits rather than encourages cooperation. Competing claims can override the goal of equity in health, which can be considered of low priority, especially in times of economic recession when economic growth can seem all-important. Then there are obstacles of a practical nature — lack of expertise and training in collaborative work, for instance. To overcome such obstacles requires, first of all, an awareness-raising exercise on the part of the health sector, to explain the true extent of the problem and increase understanding of the effects of diverse policies on health, especially that of vulnerable groups. This is a two-way process, because the health sector also needs to make itself aware of the many initiatives already happening in other sectors which have a positive effect on health. In addition, to facilitate the development of equity policy, governments need to establish administrative arrangements at national, local and regional level to encourage intersectoral action.

1. **Equity policies should be based on appropriate research, monitoring and evaluation.**

Action to reduce inequities calls for an active search for information about the real extent of the problem. This includes the systematic identification of vulnerable groups in society through the collection of appropriate health and social statistics and analysis of the social processes leading to their poorer health. In many countries, traditional statistical systems do not record such information on a routine basis and adjustments to data collection may be necessary. It also calls for closer links at national level, to coordinate the diverse work being carried out in different fields into a coherent research policy, together with international cooperation to enable cross-country analyses to be made. Monitoring and evaluation are also essential in any interventions to reduce inequities, in order to refine policies and make sure that they do no harm.

It is particularly important for health personnel to assess proposed policies and monitor their effects on access, utilization and quality of care for disadvantaged groups.

Areas of research can be:

• resource allocation in relation to social and health needs;

• geographical distribution of services linked to measures of need and access in each area;

• the experience of different social groups in their attempts to gain access to facilities, using consumer surveys where appropriate;

• quality of care, including its acceptability; and

• reasons for low uptake of essential services.

**Initiative for equity in health and health care?**

Activities are needed in following areas:

1. Policy oriented research
2. Policy oriented ongoing monitoring
3. Informed policy development and implementation

**Strategies**

1. With large scale public efforts to increase opportunities for less privileged groups, economic growth can help create opportunities to achieve more equity. However income doesn’t automatically leads to more equity.
2. Equity in health development is possible even when growth is constrained.
3. Some of the most effective and efficient strategies for equity in health are outside the health care sector.
4. Many interventions in the health sector can yield improvements at relatively low cost.
5. Efficient strategies make the best use of available resources, but saving in greater efficiency are unlikely to be sufficient. Equitable financing methods must be sought. Donor support must reinforce, not undermine, equitable policies.
6. Progress towards equity requires changes in a way resources are allocated to different social groups.
7. Some countries have been able to counterbalance the strong tendency to allocate more to those who already have more.
8. Indentifying and reaching those in greater need requires conscious, focused effort.

**Rural Credit:** It is among the most promising approaches to achieving greater equity both efficiently and effectively in recent years.

**Improving woman’s status:**

**Strengthening local organization:**

**Information for action**

1. Useful facts and figures already exist in most countries, but are underused.
2. Data on health care must be broken down according to social groups,in order to make comparisons and assess how gaps change over time.
3. Simple familiar indicators of health status and health care can be used; at least a few different measures should be assessed.
4. Both research and ongoing monitoring are needed.
5. The goal of information is to support better policies; this won’t happen unless the policy implication of facts and figures are discussed clearly.

**From information to action:**

1. Information alone is not enough : it is important to get message out, in order to mobilize public attention and achieve public consensus to ensure political will. There must be strategic thinking about political obstacles.
2. Real changes are needed in resource allocation to achieve equitable services and outcomes won’t suffice.
3. Good intentions aren’t enough: The best technical efforts must be mobilized in designing, planning, implementing and evaluating changes.
4. Health services alone won’t suffice: inter-sectoral coordination is needed to achieve equity in health development.

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